

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01861

1878

## CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rock Hall		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Napley Green		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. STREET ADDRESS Napley Green		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie A. Brooks		4. DATE OF DEATH Month Day Year Feb. 26 1956	
5. SEX F.	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26 1935
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY housekeeping	
11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benj. Hynson		14. MOTHER'S MAIDEN NAME Fannie Hinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-28-8459	
17. INFORMANT Mallie James Brooks, Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1952, to Feb. 26, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Willard F. Smith M.D. DATE SIGNED Rock Hall, Md. PHYSICIAN'S NAME (Type) Willard F. Smith Rock Hall, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 29/56	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery		22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		24a. REC'D BY REGISTRAR DATE Feb. 29/56	
24b. REGISTRAR'S SIGNATURE Wood/Burgess			

CERTIFICATE OF DEATH

1878

DATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. OCCUPATION	
5. PLACE OF BIRTH		6. DATE OF BIRTH		7. PLACE OF DEATH		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF COURT	
21. SIGNATURE OF DISTRICT ATTORNEY		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF VOTING CLERK	
25. SIGNATURE OF POLLING CLERK		26. SIGNATURE OF CANVASSER		27. SIGNATURE OF CHIEF CLERK		28. SIGNATURE OF ASSISTANT CLERK	
29. SIGNATURE OF DEPUTY CLERK		30. SIGNATURE OF CLERK IN CHARGE		31. SIGNATURE OF CLERK AT LARGE		32. SIGNATURE OF CLERK AT LARGE	
33. SIGNATURE OF CLERK AT LARGE		34. SIGNATURE OF CLERK AT LARGE		35. SIGNATURE OF CLERK AT LARGE		36. SIGNATURE OF CLERK AT LARGE	
37. SIGNATURE OF CLERK AT LARGE		38. SIGNATURE OF CLERK AT LARGE		39. SIGNATURE OF CLERK AT LARGE		40. SIGNATURE OF CLERK AT LARGE	
41. SIGNATURE OF CLERK AT LARGE		42. SIGNATURE OF CLERK AT LARGE		43. SIGNATURE OF CLERK AT LARGE		44. SIGNATURE OF CLERK AT LARGE	
45. SIGNATURE OF CLERK AT LARGE		46. SIGNATURE OF CLERK AT LARGE		47. SIGNATURE OF CLERK AT LARGE		48. SIGNATURE OF CLERK AT LARGE	
49. SIGNATURE OF CLERK AT LARGE		50. SIGNATURE OF CLERK AT LARGE		51. SIGNATURE OF CLERK AT LARGE		52. SIGNATURE OF CLERK AT LARGE	
53. SIGNATURE OF CLERK AT LARGE		54. SIGNATURE OF CLERK AT LARGE		55. SIGNATURE OF CLERK AT LARGE		56. SIGNATURE OF CLERK AT LARGE	
57. SIGNATURE OF CLERK AT LARGE		58. SIGNATURE OF CLERK AT LARGE		59. SIGNATURE OF CLERK AT LARGE		60. SIGNATURE OF CLERK AT LARGE	
61. SIGNATURE OF CLERK AT LARGE		62. SIGNATURE OF CLERK AT LARGE		63. SIGNATURE OF CLERK AT LARGE		64. SIGNATURE OF CLERK AT LARGE	
65. SIGNATURE OF CLERK AT LARGE		66. SIGNATURE OF CLERK AT LARGE		67. SIGNATURE OF CLERK AT LARGE		68. SIGNATURE OF CLERK AT LARGE	
69. SIGNATURE OF CLERK AT LARGE		70. SIGNATURE OF CLERK AT LARGE		71. SIGNATURE OF CLERK AT LARGE		72. SIGNATURE OF CLERK AT LARGE	
73. SIGNATURE OF CLERK AT LARGE		74. SIGNATURE OF CLERK AT LARGE		75. SIGNATURE OF CLERK AT LARGE		76. SIGNATURE OF CLERK AT LARGE	
77. SIGNATURE OF CLERK AT LARGE		78. SIGNATURE OF CLERK AT LARGE		79. SIGNATURE OF CLERK AT LARGE		80. SIGNATURE OF CLERK AT LARGE	
81. SIGNATURE OF CLERK AT LARGE		82. SIGNATURE OF CLERK AT LARGE		83. SIGNATURE OF CLERK AT LARGE		84. SIGNATURE OF CLERK AT LARGE	
85. SIGNATURE OF CLERK AT LARGE		86. SIGNATURE OF CLERK AT LARGE		87. SIGNATURE OF CLERK AT LARGE		88. SIGNATURE OF CLERK AT LARGE	
89. SIGNATURE OF CLERK AT LARGE		90. SIGNATURE OF CLERK AT LARGE		91. SIGNATURE OF CLERK AT LARGE		92. SIGNATURE OF CLERK AT LARGE	
93. SIGNATURE OF CLERK AT LARGE		94. SIGNATURE OF CLERK AT LARGE		95. SIGNATURE OF CLERK AT LARGE		96. SIGNATURE OF CLERK AT LARGE	
97. SIGNATURE OF CLERK AT LARGE		98. SIGNATURE OF CLERK AT LARGE		99. SIGNATURE OF CLERK AT LARGE		100. SIGNATURE OF CLERK AT LARGE	

RECEIVED  
MAR 5 1956  
BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01862

## 1879 CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Kent		MARYLAND		STATE Maryland		COUNTY Kent	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rock Hall		life		TOWN Rock Hall			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Mary		(Middle) B.		(Last) Crouch		5. DATE OF DEATH (Month) (Day) (Year)	
Fem.		White		Widowed		April 30, 1882	
SEX		COLOR OR RACE		SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		DATE OF BIRTH	
Fem.		White		Widowed		April 30, 1882	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Home		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Hodges				Fannie Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		none		Mrs. Tillie Crouch--Rock Hall, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				Pulmonary edema			
ANTECEDENT CAUSE(S) DUE TO				Cardio Vascular. Coronary Artery			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Atherosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Carcinoma of Stomach?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1953, to Feb 9, 1956, that I last saw the deceased alive on Feb 8, 1956, and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
Tillie C. Nitch				Rock Hall			
M.D.				DATE SIGNED			
Feb 10 - 56							
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Feb. 11		Wesley Chapel		Rock Hall, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Feb 10/56		S. Elwood Bengert		Edgar L. Lane		Church Hill, Md.	

# CERTIFICATE OF DEATH

DATE OF DEATH

AT WHAT RESIDENCE, HOUSE OR PLACE

MARRIAGE

HOW LONG

IN DEATH

DATE

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

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PLACE OF REINTERMENT

BUREAU V. B.

FEB 16 1956

RECEIVED

1880

01863

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 200

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN	
TOWN				TOWN <u>Millington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway west of Millington</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
John Earl Godwin				Feb. 12 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	Div.	Feb. 15, 1892	63 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farm Labor		Farm		Md.		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas Godwin				Emma Whittington			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
		217-30-8609		John Godwin - Maryland, Del.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
812X Immediate cause (a) Decapitation - To level of base of skull & complete excision of brain.						None	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
none							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		street					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Walking home & struck by vehicle			
2 12 56 2 AM.							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		Robert W. Farr, M. D.					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/14/56		Millington Cem.		Millington Kent. Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2/13/56		Edward Fellows		Edward Fellows		Millington Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 20 1956

RECEIVED



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INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1881 CERTIFICATE OF DEATH

01864

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		STATE <u>Maryland</u>		COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Worton</u>		<u>14 Yrs.</u>		TOWN <u>Worton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Andelot Farms</u>				STREET ADDRESS (If rural give location) <u>Andelot Farms</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>SUSIE</u> (Middle) <u>HOLDSON</u> (Last)				(Month) <u>Feb.</u> (Day) <u>12</u> (Year) <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 4, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Holdson</u>				14. MOTHER'S MAIDEN NAME <u>Frances Elizabeth Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>2519 Smith Ave. Mrs. Frank Holdson Balto. 30, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
199.9 IMMEDIATE CAUSE (A) <u>Probable Carcinomatosis (Primary site unknown)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>unknown</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 20, 1956</u> , to <u>Feb. 12, 1956</u> , that I last saw the deceased alive on <u>Feb. 12, 1956</u> , and that death occurred at <u>12:30A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Farr,</u>				DATE SIGNED <u>2/13/56</u>			
ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Worton, Kent Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams,</u>		ADDRESS <u>Chestertown, Md.</u>	
DATE <u>Feb. 15-1956</u>							

RECEIVED



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INSTRUCTIONS

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01865

1882 **CERTIFICATE OF DEATH**Reg. Dist. No. 203

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Rock Hall</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY OR TOWN <u>Rock Hall</u>		CITY OR TOWN <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Edsville</u>		STREET ADDRESS (If rural give location) <u>Edsville</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIAM T. HOPKINS</u>				<b>4. DATE OF DEATH</b> (Month) <u>Feb.</u> (Day) <u>8</u> (Year) <u>19 56</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>Col.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 9, 1884</u>	<b>9. AGE last birthday</b> <u>71</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>farming</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Rock Hall, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Samuel Hopkins</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Carrie Thompson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>----</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Lloyd Hopkins-RockHall, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Probable coronary thrombosis -</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>2-8, 19 56</u>, to <u>2-8, 19 56</u>, that I last saw the deceased alive on <u>2-8, 19 56</u>, and that death occurred at <u>9:30 P.</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Robert W. Jan</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Chestertown</u> <b>DATE SIGNED</b> <u>2-10-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2/11/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Sharptown Cemetery</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Rock Hall, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>2/11/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>S. Woodward Bingham</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Marvin V. Williams, Chestertown, Md.</u> <b>ADDRESS</b>			

# CERTIFICATE OF DEATH

Form 100-1-54

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Contributing cause)

11. Manner of death (Natural, Accidental, Homicide, Suicide, Unknown)

12. Signature of physician (Print name and sign)

13. Signature of medical examiner (Print name and sign)

14. Signature of coroner (Print name and sign)

15. Signature of registrar (Print name and sign)

16. Signature of funeral director (Print name and sign)

17. Signature of informant (Print name and sign)

18. Signature of witness (Print name and sign)

19. Signature of registrar (Print name and sign)

20. Signature of registrar (Print name and sign)

21. Signature of registrar (Print name and sign)

22. Signature of registrar (Print name and sign)

23. Signature of registrar (Print name and sign)

24. Signature of registrar (Print name and sign)

25. Signature of registrar (Print name and sign)

26. Signature of registrar (Print name and sign)

27. Signature of registrar (Print name and sign)

28. Signature of registrar (Print name and sign)

BUREAU V. S.

FEB 16 1956

RECEIVED

NOTIFICATION  
The undersigned hereby certifies that the foregoing is a true and correct copy of the original certificate of death filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

Signature of Registrar  
Name of Registrar  
Title of Registrar

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01866

## 1883 CERTIFICATE OF DEATH

Reg. Dist. No. 200

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>GALENA</u>				TOWN <u>GALENA</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>PALMER</u> (Middle) <u>KEENE</u> (Last) <u>HORSEY</u>				FEB. 9 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	MARRIED	JAN. 1, 1892	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
PAINTER		PAINTER		MD.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS H. HORSEY				MARY E. RASIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		NONE		MRS. AUDREY B. HORSEY, GALENA, MD.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Disease</u>				Sudden			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				6 mo			
DUE TO (B) _____							
DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED (White el work <input type="checkbox"/> Not white at work <input type="checkbox"/> M. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1</u> , 19 <u>49</u> , to <u>Feb 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>56</u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H. H. Harrington</u>				ADDRESS (Street, city, town, state) <u>Willington Md</u>		DATE SIGNED <u>2/10/56</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		FEB. 11, 1956		SHREWSBURY CEM.		RURAL KENNEDYVILLE MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7/11/56</u>		<u>E. Elizabeth J. Muehl</u>		<u>Edward Fellows</u>		<u>Willington Md</u>	

SHORT SUBJECT

1. Name of the deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Name of the physician  
6. Name of the funeral home  
7. Name of the undertaker  
8. Name of the cemetery  
9. Name of the church  
10. Name of the family  
11. Name of the friends  
12. Name of the neighbors  
13. Name of the community  
14. Name of the country  
15. Name of the world

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of the deceased

2. Date of death  
3. Place of death  
4. Cause of death

5. Name of the physician  
6. Name of the funeral home  
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8. Name of the cemetery  
9. Name of the church  
10. Name of the family

11. Name of the friends  
12. Name of the neighbors  
13. Name of the community

14. Name of the country  
15. Name of the world

16. Name of the state  
17. Name of the nation  
18. Name of the world

19. Name of the universe  
20. Name of the cosmos  
21. Name of the universe

22. Name of the universe  
23. Name of the cosmos  
24. Name of the universe

RECEIVED

FEB 14 1935

BUREAU V. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1872

CERTIFICATE OF DEATH

01867

Reg. Dist. No. 2021

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> (lifetime) <b>X</b>				d. STREET ADDRESS <b>Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>72 Kent &amp; Queen Anne Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NATHANIEL</b>		First		Middle		Last <b>HYNSON</b>	
4. DATE OF DEATH <b>Feb 18 1956</b>		Month		Day		Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1903</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Hynson</b>				14. MOTHER'S MAIDEN NAME <b>Martha Bailey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-I2-6724</b>		17. INFORMANT <b>Letitia Hynson</b> Address <b>Rock Hall, Md. R.R. # I</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia</b> <b>604X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Probable urinary lithiasis +</b> DUE TO (c) <b>renal infection</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-17, 1956</b> to <b>2-18, 1956</b> that I last saw the deceased alive on <b>2-18, 1956</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>2-18-56</b>							
ACTUAL SIGNATURE <b>Robert W. Farr</b> M.D.				PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE OF <b>Feb. 21 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sharptown</b>		22d. LOCATION (City, town, or county) (State) <b>near - Rock Hall, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>				ADDRESS <b>Chestertown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Feb 20-1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>			



CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. AGE <i>45</i>		4. RACE <i>WHITE</i>	
5. DATE OF BIRTH <i>1910</i>		6. PLACE OF BIRTH <i>NEW YORK</i>	
7. DATE OF DEATH <i>1955</i>		8. PLACE OF DEATH <i>HOSPITAL</i>	
9. CAUSE OF DEATH <i>HEART DISEASE</i>		10. MANNER OF DEATH <i>NATURAL</i>	
11. SIGNATURE OF PHYSICIAN <i>DR. J. H. SMITH</i>		12. SIGNATURE OF REGISTRAR <i>JOHN J. SMITH</i>	
13. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		14. SIGNATURE OF NEXT OF KIN <i>JOHN J. SMITH</i>	
15. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		16. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
17. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		18. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
19. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		20. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
21. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		22. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
23. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		24. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
25. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		26. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
27. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		28. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
29. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		30. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
31. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		32. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
33. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		34. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
35. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		36. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
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47. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		48. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
49. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		50. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
51. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		52. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
53. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		54. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
55. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		56. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
57. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		58. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
59. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		60. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
61. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		62. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
63. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		64. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
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67. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		68. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
69. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		70. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
71. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		72. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
73. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		74. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
75. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		76. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
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79. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		80. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
81. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		82. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
83. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		84. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
85. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		86. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
87. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		88. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
89. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		90. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
91. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		92. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
93. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		94. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
95. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		96. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
97. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		98. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
99. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		100. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	

BUREAU V. S.

FEB 23 1956

RECEIVED



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01868

## 1884 CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rock Hall</u>				TOWN <u>Rock Hall R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lyla</u> (Middle) <u>Catherine</u> (Last) <u>Kircher</u>				(Month) <u>Feb</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>		<u>Feb 4 - 1903</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Home</u>		<u>Home</u>		<u>Iowa</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Otto Lassen</u>				<u>Agusta Walter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>217-36-0757</u>		<u>Trudy Kircher Rock Hall</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
434.0 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac enlargement, emphysema, marked</u>						<u>12 hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>kyphosis of spine (probably due to Pott's disease of spine as child)</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1, 1953</u> , to <u>Feb. 28, 1956</u> , that I last saw the deceased alive on <u>Feb. 28, 1956</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wieland F. Smith</u>				ADDRESS (Street, city, town, state) <u>Rock Hall, Md.</u>		DATE SIGNED <u>3/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>3-2-56</u>		<u>Chester</u>		<u>Chesletown</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/2/56</u>		<u>S. Wood Burgess</u>		<u>Edgar L. Lane</u>		<u>Church Hill</u>	

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01869

## 1873 CERTIFICATE OF DEATH

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Chestertown</u>		<u>1 day</u>		TOWN <u>Rock Hall Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent &amp; Queen Anne General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>CLADYS ESTELLIE LAMBERT</u>				<u>2 16 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 2, 1895</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Owen Donnelly</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Wrie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>George T. Lambert, Rock Hall Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary insufficiency - acute</u>						<u>1 hour</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Probable coronary sclerosis - unknown</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I <u>examined</u> the deceased from <u>11:15</u> to <u>11:15</u> , 19 <u>56</u> , that I last saw the deceased <u>live on 2-16</u> , 19 <u>56</u> , and that death occurred at <u>1:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Robert W. ...</u>				DATE SIGNED <u>2-16-56</u>			
M.D.				ADDRESS (Street, city, town, state) <u>Chestertown, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>Feb. 19</u>		<u>Wesley Chapel</u>		<u>Rock Hall Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 20 - 1956</u>		<u>Charles S. Barnes</u>		<u>Edgar H. Lane</u>		<u>Chubb Hill Md.</u>	

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1874

## CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown, Md</b>				c. LENGTH OF STAY IN 1b <b>13 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hosp.</b>				d. STREET ADDRESS <b>Rock Hall</b>			
3. NAME OF DECEASED (Type or print) <b>SUSTE E. LEARY</b>				4. DATE OF DEATH <b>2/26/56</b> 19 <b>56</b>			
5. SEX <b>F...</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>March, 25, 1882</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac L. Leary</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Maslin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-6023</b>		17. INFORMANT <b>Wm. E. Leary</b> Address <b>Rock Hall, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>9042</b> (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, lft Hip. Open Reduction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-13-56</b> , to <b>2-26-56</b> , that I last saw the deceased alive on <b>2-26-56</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, Md</b> DATE SIGNED <b>2-26-56</b>							
ACTUAL SIGNATURE <b>G. T. Keefe</b>				M.D. <b>CHESTERTOWN, Md</b>			
PHYSICIAN'S NAME (Type) <b>Arthur T. Keefe</b>				Chesertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/29/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams, Chestertown, Md.</b>				24a. REC'D BY REGISTRAR <b>Marvin V. Williams</b>		24b. REGISTRAR'S SIGNATURE <b>Class J. Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

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1885

## CERTIFICATE OF DEATH

Reg. Dist. No. *202*

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Highway between Worton &amp; Syndeh, Md.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <i>RFD (Fairlee)</i>		
3. NAME OF DECEASED (Type or print) <i>Mattie M. Meredith</i>			4. DATE OF DEATH Month <i>2</i> Day <i>21</i> Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-18</i>	9. AGE (In years last birthday) <i>38</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Talbot Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>James L. Cummings</i>		
14. MOTHER'S MAIDEN NAME <i>Lydia Marshall</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		
16. SOCIAL SECURITY NO. <i>216-10-3558</i>			17. INFORMANT <i>Wm. C. Meredith</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture cervical vertebra (approx C4-6)</i> <i>829X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>None</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.) <i>Ran off road about 1/2 mile 2/21/56 &amp; was thrown out of car when it turned over several times</i>		
20c. TIME OF INJURY Month Day Year <i>2-21 1956</i>			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>			20f. (City or town) (County) (State) <i>New Worton Kent Md</i>		
21. I certify that I attended the deceased from <i>2-21</i> , 19 <i>56</i> , to <i>Feb 21</i> , 19 <i>56</i> , and that death occurred at <i>11</i> , from the causes and on the date stated above. alive on <i>death on 2/21</i> , 19 <i>56</i> , and that death occurred at <i>11</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Robert W. Farr</i>			ADDRESS (Street, city or town, state) <i>Chestertown, Md.</i>		
PHYSICIAN'S NAME (Type) <i>Robert W. Farr, M. D.</i>			DATE SIGNED <i>Feb. 21, 1956</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/23/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chester Cem.</i>	
22d. LOCATION (City, town, or county) (State) <i>Chestertown, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>2-21-56</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Barnes</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Wells</i>		ADDRESS <i>Chestertown, Md.</i>			

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1887

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>Feb 27 1905</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. H. Smith</i></p>		<p>8. Signature of registrar: <i>John Doe</i></p>	
<p>9. Signature of informant: <i>John Doe</i></p>		<p>10. Signature of witness: <i>John Doe</i></p>	
<p>11. Signature of registrar: <i>John Doe</i></p>		<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of registrar: <i>John Doe</i></p>		<p>14. Signature of witness: <i>John Doe</i></p>	
<p>15. Signature of registrar: <i>John Doe</i></p>		<p>16. Signature of witness: <i>John Doe</i></p>	
<p>17. Signature of registrar: <i>John Doe</i></p>		<p>18. Signature of witness: <i>John Doe</i></p>	
<p>19. Signature of registrar: <i>John Doe</i></p>		<p>20. Signature of witness: <i>John Doe</i></p>	
<p>21. Signature of registrar: <i>John Doe</i></p>		<p>22. Signature of witness: <i>John Doe</i></p>	
<p>23. Signature of registrar: <i>John Doe</i></p>		<p>24. Signature of witness: <i>John Doe</i></p>	
<p>25. Signature of registrar: <i>John Doe</i></p>		<p>26. Signature of witness: <i>John Doe</i></p>	
<p>27. Signature of registrar: <i>John Doe</i></p>		<p>28. Signature of witness: <i>John Doe</i></p>	
<p>29. Signature of registrar: <i>John Doe</i></p>		<p>30. Signature of witness: <i>John Doe</i></p>	
<p>31. Signature of registrar: <i>John Doe</i></p>		<p>32. Signature of witness: <i>John Doe</i></p>	
<p>33. Signature of registrar: <i>John Doe</i></p>		<p>34. Signature of witness: <i>John Doe</i></p>	
<p>35. Signature of registrar: <i>John Doe</i></p>		<p>36. Signature of witness: <i>John Doe</i></p>	
<p>37. Signature of registrar: <i>John Doe</i></p>		<p>38. Signature of witness: <i>John Doe</i></p>	
<p>39. Signature of registrar: <i>John Doe</i></p>		<p>40. Signature of witness: <i>John Doe</i></p>	
<p>41. Signature of registrar: <i>John Doe</i></p>		<p>42. Signature of witness: <i>John Doe</i></p>	
<p>43. Signature of registrar: <i>John Doe</i></p>		<p>44. Signature of witness: <i>John Doe</i></p>	
<p>45. Signature of registrar: <i>John Doe</i></p>		<p>46. Signature of witness: <i>John Doe</i></p>	
<p>47. Signature of registrar: <i>John Doe</i></p>		<p>48. Signature of witness: <i>John Doe</i></p>	
<p>49. Signature of registrar: <i>John Doe</i></p>		<p>50. Signature of witness: <i>John Doe</i></p>	
<p>51. Signature of registrar: <i>John Doe</i></p>		<p>52. Signature of witness: <i>John Doe</i></p>	
<p>53. Signature of registrar: <i>John Doe</i></p>		<p>54. Signature of witness: <i>John Doe</i></p>	
<p>55. Signature of registrar: <i>John Doe</i></p>		<p>56. Signature of witness: <i>John Doe</i></p>	
<p>57. Signature of registrar: <i>John Doe</i></p>		<p>58. Signature of witness: <i>John Doe</i></p>	
<p>59. Signature of registrar: <i>John Doe</i></p>		<p>60. Signature of witness: <i>John Doe</i></p>	
<p>61. Signature of registrar: <i>John Doe</i></p>		<p>62. Signature of witness: <i>John Doe</i></p>	
<p>63. Signature of registrar: <i>John Doe</i></p>		<p>64. Signature of witness: <i>John Doe</i></p>	
<p>65. Signature of registrar: <i>John Doe</i></p>		<p>66. Signature of witness: <i>John Doe</i></p>	
<p>67. Signature of registrar: <i>John Doe</i></p>		<p>68. Signature of witness: <i>John Doe</i></p>	
<p>69. Signature of registrar: <i>John Doe</i></p>		<p>70. Signature of witness: <i>John Doe</i></p>	
<p>71. Signature of registrar: <i>John Doe</i></p>		<p>72. Signature of witness: <i>John Doe</i></p>	
<p>73. Signature of registrar: <i>John Doe</i></p>		<p>74. Signature of witness: <i>John Doe</i></p>	
<p>75. Signature of registrar: <i>John Doe</i></p>		<p>76. Signature of witness: <i>John Doe</i></p>	
<p>77. Signature of registrar: <i>John Doe</i></p>		<p>78. Signature of witness: <i>John Doe</i></p>	
<p>79. Signature of registrar: <i>John Doe</i></p>		<p>80. Signature of witness: <i>John Doe</i></p>	
<p>81. Signature of registrar: <i>John Doe</i></p>		<p>82. Signature of witness: <i>John Doe</i></p>	
<p>83. Signature of registrar: <i>John Doe</i></p>		<p>84. Signature of witness: <i>John Doe</i></p>	
<p>85. Signature of registrar: <i>John Doe</i></p>		<p>86. Signature of witness: <i>John Doe</i></p>	
<p>87. Signature of registrar: <i>John Doe</i></p>		<p>88. Signature of witness: <i>John Doe</i></p>	
<p>89. Signature of registrar: <i>John Doe</i></p>		<p>90. Signature of witness: <i>John Doe</i></p>	
<p>91. Signature of registrar: <i>John Doe</i></p>		<p>92. Signature of witness: <i>John Doe</i></p>	
<p>93. Signature of registrar: <i>John Doe</i></p>		<p>94. Signature of witness: <i>John Doe</i></p>	
<p>95. Signature of registrar: <i>John Doe</i></p>		<p>96. Signature of witness: <i>John Doe</i></p>	
<p>97. Signature of registrar: <i>John Doe</i></p>		<p>98. Signature of witness: <i>John Doe</i></p>	
<p>99. Signature of registrar: <i>John Doe</i></p>		<p>100. Signature of witness: <i>John Doe</i></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon paper.  
The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18

Item 8.9 FilmG19 3-20-56 et

1886

CERTIFICATE OF DEATH

01872

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>Bent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Bent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Galena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Galena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN P. RILEY</u>		4. DATE OF DEATH Month Day Year <u>Feb 23 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u> 9. AGE (In years lost birthday) yrs. <u>Approx. 72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
13. FATHER'S NAME <u>Robert Peaker</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Kerry Riley</u> Address <u>Baltimore md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1950</u> , 19 <u>50</u> , to <u>Feb 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>55</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Millington</u> DATE SIGNED <u>2/25/56</u>			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		M.D. <u>Millington</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 26 1956</u>	<u>Christ Hill Cem</u>	<u>Rural Galena md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Villous</u>		24a. REC'D BY REGISTRAR <u>Millington md</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth Mulford</u>

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1885

and day of

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

MAR 2 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1875 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				01873 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 202					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Kent</u>		MARYLAND	STATE <u>Md</u>		COUNTY <u>Kent</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Chestertown</u>		LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Chestertown</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>High St.</u>		STREET ADDRESS (If rural, give location) <u>High St.</u>			
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Joseph</u> (Middle) <u>Harry</u> (Last) <u>SCHAUBER</u>			(Month) <u>Feb</u> (Day) <u>5</u> (Year) <u>1956</u>		
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>Dec. 23, 1947</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>8</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Kent Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Joseph Schaubert</u>			14. MOTHER'S MAIDEN NAME: <u>Mary George</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mother Chestertown Maryland</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Suffocation</u>					<u>a few minutes</u>
DUE TO					
Antecedent cause(s) (b) <u>Head &amp; neck were caught between gears</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>elevators landing and elevator</u>					
DUE TO					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>grain elevator</u>		21c. (City or town) (County) (State) <u>Chestertown Kent Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 5 1956 4:20 PM</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>was playing on grain elevator &amp; fell</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Rbert W. Farr</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb 5 - 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/8 /1956</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		ADDRESS <u>Chestertown Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 6 - 1956</u>		REGISTRAR'S SIGNATURE <u>Class L. Barnes</u>			

RECEIVED  
FEB 8 1956  
BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01874

1887 **CERTIFICATE OF DEATH**Reg. Dist. No. 201

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FAIRLEE</u>		LENGTH OF STAY (in this place) <u>6 MOS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>KENNEDYVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>STRONG NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>—</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>SARAH ELIZABETH SCOTTEN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>FEB. 6 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>NOV. 29, 1865</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN SCOTTEN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GREENWOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>ETHEL GREENWOOD STILL POND, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
491X IMMEDIATE CAUSE (A) <u>PNEUMONIA - BRONCHIAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Stroke -</u>						<u>6 or 7 months</u>	
19a. DATE OF OPERATION <u>D</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 4, 1953</u> , to <u>2-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-6</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>R. Lee W. Fair</u> <b>DATE SIGNED</b> <u>2/7/56</u> M.D. <u>Chestertown, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 9, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>GALENA CEMETERY</u>		LOCATION (City, town, or county) (State) <u>GALENA, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>2/7/56</u>		REGISTRAR'S SIGNATURE <u>E. Keenard Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u>		ADDRESS <u>STILL POND, MD.</u>	

# CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

EDUCATION

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTY

—

—

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

BUREAU V. S.

FEB 9 1956

RECEIVED

FEB 9 1956

FEB 9 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1888

## CERTIFICATE OF DEATH

01875

Reg. Dist. No.

203

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rock Hall</b>				c. LENGTH OF STAY IN 1b <b>adult Life</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>				X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 Rural (Reese's Corner)</b>				d. STREET ADDRESS <b>Rural (Reese's Corner)</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Olan</b> Middle <b>David</b> Last <b>Simpkins</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1895</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>		11. BIRTHPLACE (State or foreign country) <b>Wilmington, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Hart Simpkins</b>				14. MOTHER'S MAIDEN NAME <b>Queen Victoria Baxter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-36-0911</b>		17. INFORMANT <b>Franklin Simpkins</b> Address <b>Rock Hall, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia &amp; acidosis</b> <b>181X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of bladder</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>about 2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 1, 1955</b> , to <b>Feb. 26, 1956</b> , that I last saw the deceased alive on <b>Feb. 26, 1956</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard F. Smith</b>		M.D.		ADDRESS (Street, City or town, state) <b>Rock Hall, Md.</b>		DATE SIGNED <b>Feb. 27, 56</b>	
PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 29, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Feb. 29/56</b>	24b. REGISTRAR'S SIGNATURE <b>S. Elwood Banger</b>		

BUREAU V. S.

MAR 5 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01876

## 1876 CERTIFICATE OF DEATH

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 222 Washington Avenue</u>				STREET ADDRESS (If rural give location) <u>222 Washington Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>MARY</u> <u>Edith</u> <u>Thomey</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 9</u> <u>1956</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>		<b>8. DATE OF BIRTH</b> <u>July 21, 1890</u>	
<b>9. AGE last birthday</b> <u>65</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Registered nurse</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Nursing</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>JAMES Dunbracco</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary A. Hendricks</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-01-4530 A</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Sue W. Broome, Chestertown, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>153X IMMEDIATE CAUSE (A)</b> <u>Metastatic carcinoma</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 years</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Carcinoma of colon</u>						<u>3 years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>JUNE 1953</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>CARCINOMA of colon &amp; metastases</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>August</u> , 19 <u>55</u> , to <u>Feb 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>56</u> , and that death occurred at <u>1:57</u> P.M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. Dick</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Chestertown, Md.</u>		<b>DATE SIGNED</b> <u>2-9-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. II, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Chester Cemetery</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Chestertown, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>Feb. 11-1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Clara S. Barnes</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Willis Wells</u>		<b>ADDRESS</b> <u>Chestertown Maryland</u>	





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## 1877 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>				c. LENGTH OF STAY IN 1b <u>19 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 201 S. Water Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marie Josephine Grinter Whitsett</u>				4. DATE OF DEATH <u>February 19 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5, 1903</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas City Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emory F. Grinter</u>				14. MOTHER'S MAIDEN NAME <u>Wavifred Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>A.F. Whitsett, Chestertown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of breasts</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec. 15, 1956</u> , to <u>Feb. 19, 1956</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>56</u> , and that death occurred at <u>7:00 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2-19-56</u>							
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. <u>Chestertown, Md</u>							
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u> <u>A. C. Dick - Chestertown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saint Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>nr. - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2-21-1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 23 1956

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